MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Dr. B 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-03-7781-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Dallas Area Rapid Transit c/o ACE USA/ESIS Box 15	Date of Injury: Employer's Name: Insurance Carrier's No.: 00945001223 001

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/17/02	**12/06/02**	**97139-PH**	**$140.00**	

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 06/10/03 states in part, "…The carrier paid partial payment of our charge code 97139-PH. TWCC does not have a MAR set for this procedure code; however, our usual and customary charge is $50.00, which $35.00 has been excepted by TWCC as usual and customary reimbursement…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary dated 08/01/03 states in part, "…Provider has billed $50.00 per treatment date. Carrier asserts that this amount exceed what would be a fair and reasonable reimbursement for this service. Carrier maintains that its reimbursement of $28.00 for the services and $7.00 for the supplies is fair and reasonable. These figure are within a close range of reimbursement for other analogous forms of supervised therapy such as whirlpool therapy under CPT Code 97022 (MAR = $20); ultrasound under CPT 97035 (MAR = $22); and Hubbard tank under CPT 97032 (MAR = $29). No additional reimbursement has been established as reasonable or necessary…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 97139-PH for dates of service 10/17/02, 10/18/02, 10/22/02, 10/24/02, 11/06/02, 11/13/02, 11/18/02, 11/19/02, 11/27/02, 11/29/02, 12/03/02, 12/04/02, 12/05/02, and 12/06/02 denied as "111 – FHN contract status indicator 02 – Non Contracted Provider". The requestor billed $50.00 per unit stating in their position summary that this amount was their usual and customary. In the requestor's letter for request for reconsideration the requestor states their usual and customary charge is $45.00 per unit. The requestor is seeking a total of $35.00 per treatment. The respondent paid $28.00 per session. This code is a DOP code and has no MAR. Per 133.1(8) the requestor has not provided any documentation to support the amount they are seeking is their usual and customary amount; therefore, additional reimbursement is not recommended.
- CPT Code 97139-PH for dates of service 10/31/02, 11/02/02 and 11/05/02 denied as "S – Supplemental payment". The code is a DOP code and has no MAR. Per 133.1(8) the requestor has not provided any documentation to support the amount they are seeking is their usual and customary amount. For date of service 11/02/02 the carrier paid a total amount of $7.00, which according to the submitted EOBs all other dates of service using this CPT code were paid $28.00 per unit; therefore, reimbursement of $21.00 for date of service 11/02/02 is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
11/17/02 -							
12/6/2002	97139-PH	$140.00	$21.00				
					Total Left Column:		$140.00
					Total Amount Due:		$21.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $21.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Marguerite Foster Typed Name	1-07-05 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____